

10153

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>35yrs.4mo.9days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>North Carolina</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thomasville</b> d. STREET ADDRESS <b>8 College Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>Q.</b> Last <b>ADAMS</b>		4. DATE OF DEATH Month <b>September</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-13-82</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nathan Ward</b>		14. MOTHER'S MAIDEN NAME <b>Alice Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral unresolved</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Tuberculosis of the lung, moderately advanced</b> DUE TO <b>active</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized severe</b> INTERVAL BETWEEN ONSET AND DEATH <b>6-7 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 25</b> , 19 <b>24</b> , to <b>September 3</b> , 19 <b>59</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>D.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>9-4-59</b>			
ACTUAL SIGNATURE <b>J. L. GAREY</b>		M.D. <b>V.A. Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-4-59</b>		22b. DATE THEREOF <b>9-4-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>City</b>		22d. LOCATION (City, town, or county) (State) <b>Thomasville, North Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE A. PATTERSON, Perryville, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Chas. L. Harris</b>			

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10153

THE WHITE OF DEB

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[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some words like "active" and "investigation" are faintly visible.]

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10154

Item 14 Film G248 9-17-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colora. R.D.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dinsmore Garage, West Main St.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Ashley</b> Last				4. DATE OF DEATH Month <b>9</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-18-1890</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sign Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Ashley</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>105-14-3254</b>		17. INFORMANT <b>Mrs. Frank Ashley, Edge wood, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of large Bowel</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b> EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Sept. 12, 1959</b>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>New Bridge Baptist Cem.</b>	
22d. LOCATION (City, town, or county) <b>Colora</b>				22e. (State) <b>md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson</b>				ADDRESS <b>Rising Sun, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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VS A15 (4)  
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10128

10155

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>STORR</b> Last <b>BLACK</b>		4. DATE OF DEATH Month <b>September</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January, 14, 1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Vienia, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Storr</b>		14. MOTHER'S MAIDEN NAME <b>Lydia E. Hodson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss, Margaret H. Black,</b>		Address <b>Cecilton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>chronic gastric ulcer</b> <b>584x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic cholecystitis with cholelithiasis</b> DUE TO (c) <b>10 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1949</b> , to <b>Sept 22, 1959</b> , that I last saw the deceased alive on <b>Sept 21, 1959</b> , and that death occurred at <b>3:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MIDDLETOWN, DEL</b> DATE SIGNED <b>9-23-59</b>			
ACTUAL SIGNATURE <b>ALLAN R. CRUCKLEY</b> M.D.		PHYSICIAN'S NAME (Type) <b>ALLAN R. CRUCKLEY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>September 24, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton, Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cecilton, Cecil Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Hellows</b>		24a. REC'D BY REGISTRAR <b>DATE SEP 25 '59</b>	
ADDRESS <b>Mellington Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur B. Frank</b>	

CERTIFICATE OF DEATH

20152

NAME OF DECEASED <b>John H. Brown</b>		DATE OF BIRTH <b>April 1, 1895</b>	
PLACE OF BIRTH <b>St. Louis, Mo.</b>		DATE OF DEATH <b>April 1, 1975</b>	
AGE <b>80 years</b>		PLACE OF DEATH <b>St. Louis, Mo.</b>	
SEX <b>Male</b>		RACE <b>White</b>	
MARRIAGE <b>Married</b>		EDUCATION <b>High School</b>	
OCCUPATION <b>Retired</b>		RELIGION <b>Methodist</b>	
US BIRTH <b>Yes</b>		CITIZENSHIP <b>Yes</b>	
MILITARY SERVICE <b>None</b>		VETERAN <b>No</b>	
PREVIOUS DEATHS <b>None</b>		CAUSE OF DEATH <b>Heart Disease</b>	
IMMEDIATE CAUSE <b>Myocardial Infarction</b>		MANNER OF DEATH <b>Natural</b>	
INTERMEDIATE CAUSE <b>Coronary Artery Disease</b>		FUNDAMENTAL CAUSE <b>Arteriosclerosis</b>	
PRE-EXISTING DISEASES <b>Hypertension, Diabetes</b>		TREATMENT <b>Medical</b>	
DATE OF EXAMINATION <b>April 1, 1975</b>		PLACE OF EXAMINATION <b>St. Louis, Mo.</b>	
NAME OF PHYSICIAN <b>Dr. J. H. Brown</b>		NAME OF PATHOLOGIST <b>Dr. J. H. Brown</b>	
NAME OF CORONER OR DEPUTY <b>John H. Brown</b>		NAME OF COUNTY CLERK <b>John H. Brown</b>	
NAME OF CITY CLERK <b>John H. Brown</b>		NAME OF STATE CLERK <b>John H. Brown</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10156

### CERTIFICATE OF DEATH

10129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>3 mos. 7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>E.</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1915</b>
9. AGE (In years lost birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry O. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Elliott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-II 216-07-5764</b>	
17. INFORMANT <b>Hospital Records, VAH., Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved.</b> DUE TO (b) <b>Carcinoma, right floor of mouth, with metastasis to both lungs.</b> DUE TO (c) <b>Unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 18, 19 59</b> , to <b>September 25, 19 59</b> , and that death occurred at <b>3:20 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA Hospital, Perry Point, Md.</b> DATE SIGNED <b>9-25-59</b>			
ACTUAL SIGNATURE <b>J. L. Garey</b>		M.D. <b>VA Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Chestertown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WELLS FUNERAL HOME, Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

MAILED 217 DEPARTMENT OF HEALTH AND HUMAN SERVICES

1100

## Analysis

June 11

1948-1949

UNION TYPE 1

Verfahren: Administration

111 College Avenue

1023-1110

July 1910

44

bioRxiv preprint doi: <https://doi.org/10.1101/000000>; this version posted January 1, 2016. The copyright holder for this preprint (which was not certified by peer review) is the author/funder, who has granted bioRxiv a license to display the preprint in perpetuity. It is made available under aCC-BY-NC-ND 4.0 International license.

1990

NOTE: 1. When the number of observations is small, the results may be biased. 2. The results are based on the assumption that the data are normally distributed.

1991-1992

11-22

24Y

210-07-2766 Hospital Records, VAN, Perry Point, Md.

Бронхопневмония, bilateral, varicella.

to both lungs.

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VA Hospital, Perry Point, Md. 2-27-55

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10130

10157

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>DELAWARE</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>23 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>P.</b> Last <b>CAPLE</b>		4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 31, 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Hospital Records, VA Hospital, Perry Point, Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic necrosis of right lung secondary to leak from esophago-jejuno anastomosis</b> 539.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 15, 1959</b> to <b>September 7, 1959</b> and that death occurred at <b>7:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>9-8-59</b>			
ACTUAL SIGNATURE <b>Bernard S. Linn</b>		M.D. <b>V.A. Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>B. S. LINN</b>		Staff Physician	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried 9-8-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Marvin</b>		22d. LOCATION (City, town, or county) (State) <b>Marvin, North Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE A. PATTERSON, Perryville, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>			
c. LENGTH OF STAY IN 1b <b>10 yrs</b>				d. STREET ADDRESS <b>Cherry</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cherry</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Henry</b> Last <b>Cather</b>				4. DATE OF DEATH Month <b>9</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-6-1877</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Cecil Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Cather</b>				14. MOTHER'S MAIDEN NAME <b>Martha Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mary Cather, Cherry St., Rising Sun, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>9-20-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas E. McMiller Rising Sun, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>SEP 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carroll L. Travis</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10132

Reg. Dist. No. 96

10159

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>			
c. LENGTH OF STAY IN 1b <b>14 year</b>				d. STREET ADDRESS <b>301 Willow Avenue</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital, Perry Point, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CHARLES</b> Middle <b>H.</b> Last <b>DIETZ</b>				<b>4. DATE OF DEATH</b> Month <b>9</b> Day <b>11</b> Year <b>1959</b>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>12-8-21</b>	
<b>9. AGE</b> (In years last birthday) <b>37</b> yrs.		<b>IF UNDER 1 YEAR</b> Months      Days		<b>IF UNDER 24 HRS.</b> Hours      Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Lab. Tech.</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hospital</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>CHARLES DIETZ</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>CATHERINE MOYLAN</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b>		<b>16. SOCIAL SECURITY NO.</b> <b>UNKNOWN</b>		<b>17. INFORMANT</b> Address <b>HOSPITAL RECORDS, VAH, PERRY POINT, MD.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>DROWNED</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> _____							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Causes Unknown- Body Found In River</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>6:20?</b> a. m. <b>9-</b> 11-1959 p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Susquehanna River, Perry Point, Cecil, Md.</b>	
<b>20f. (City or town)</b> (County)      (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>R.C. Dodson</i>				<b>DATE SIGNED</b> <b>9-13-59</b>			
<b>EXAMINER'S NAME (Type)</b> <b>R.C. DODSON, M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>9/17/59</b>		<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Baltimore, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>For Hand</i>				<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>DATE SEP 18 '59</b> <i>Arthur J. Kline</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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10145

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MARY</u> Last <u>EDER</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1896</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN SHIVERY</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH MARCUS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MR. A. ROY EDER</u> Address <u>ELKTON, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic coronary artery disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary thrombosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>36 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Sept. 8</u> , 19 <u>59</u> , to <u>Sept. 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 21</u> , 19 <u>59</u> , and that death occurred at <u>1:15a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>233 E. Main Street</u>				DATE SIGNED <u>9/23/59</u>			
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT 23, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ELKTON Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		ADDRESS <u>Elkton Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '59</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



10146

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Edwards				4. DATE OF DEATH Month Day Year Sept. 26 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1959	
9. AGE (In years lost birthday) yrs. 13		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Raby S. Edwards				14. MOTHER'S MAIDEN NAME Irene B. Bwing			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
INFORMANT Mr. Raby S. Edwards, North East, R.D. 1, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease - Intraauricular Septal Defect 7543 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 25 Sept, 1959 to 26 Sept, 1959 that I last saw the deceased alive on 26 Sept, 1959, and that death occurred at 10:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Hechner M.D.				ADDRESS (Street, city or town, state) North East, Md. DATE SIGNED 26 Sept '59			
PHYSICIAN'S NAME (Type) Klaus H. Hechner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/59		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem North East Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				24a. REC'D BY REGISTRAR DATE SEP 29 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Harris							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10148

CERTIFICATE OF DEATH

WILLIAM STATE OF VIRGINIA DEPARTMENT OF HEALTH

10148

Blank certificate form with horizontal lines for text entry.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10135

10160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, Rural</b>			c. LENGTH OF STAY IN 1b <b>10 yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, R.D.#2</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Margarett</b> Middle <b>H</b> Last <b>Flemming</b>				4. DATE OF DEATH Month <b>9</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 10, 1908</b>		9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Hauberdratz</b>				14. MOTHER'S MAIDEN NAME <b>no information</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-36-2577</b>		17. INFORMANT <b>Margaret Hayward</b> Address <b>Phila, Pa</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>9-9-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Elkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pippin Funeral Home</b>				ADDRESS <b>Elkton, Md</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 14 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kline</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  GEORGE J. HANCOCK</p>		<p>2. SEX                  Male</p>		<p>3. AGE                  65</p>	
<p>4. DATE OF DEATH                  10-10-1913</p>		<p>5. PLACE OF DEATH                  100 West 10th St., Boston</p>		<p>6. OCCUPATION                  Clerk</p>	
<p>7. CAUSE OF DEATH                  Myocardial Infarction</p>		<p>8. MANNER OF DEATH                  Natural</p>		<p>9. SIGNATURE OF EXAMINER                  J. J. [Signature]</p>	
<p>10. SIGNATURE OF NEXT OF KIN                  [Signature]</p>		<p>11. SIGNATURE OF MINISTER OF THE GOSPEL                  [Signature]</p>		<p>12. SIGNATURE OF CLERK                  [Signature]</p>	
<p>13. SIGNATURE OF JURY                  [Signature]</p>		<p>14. SIGNATURE OF JURY                  [Signature]</p>		<p>15. SIGNATURE OF JURY                  [Signature]</p>	
<p>16. SIGNATURE OF JURY                  [Signature]</p>		<p>17. SIGNATURE OF JURY                  [Signature]</p>		<p>18. SIGNATURE OF JURY                  [Signature]</p>	
<p>19. SIGNATURE OF JURY                  [Signature]</p>		<p>20. SIGNATURE OF JURY                  [Signature]</p>		<p>21. SIGNATURE OF JURY                  [Signature]</p>	
<p>22. SIGNATURE OF JURY                  [Signature]</p>		<p>23. SIGNATURE OF JURY                  [Signature]</p>		<p>24. SIGNATURE OF JURY                  [Signature]</p>	
<p>25. SIGNATURE OF JURY                  [Signature]</p>		<p>26. SIGNATURE OF JURY                  [Signature]</p>		<p>27. SIGNATURE OF JURY                  [Signature]</p>	
<p>28. SIGNATURE OF JURY                  [Signature]</p>		<p>29. SIGNATURE OF JURY                  [Signature]</p>		<p>30. SIGNATURE OF JURY                  [Signature]</p>	
<p>31. SIGNATURE OF JURY                  [Signature]</p>		<p>32. SIGNATURE OF JURY                  [Signature]</p>		<p>33. SIGNATURE OF JURY                  [Signature]</p>	
<p>34. SIGNATURE OF JURY                  [Signature]</p>		<p>35. SIGNATURE OF JURY                  [Signature]</p>		<p>36. SIGNATURE OF JURY                  [Signature]</p>	
<p>37. SIGNATURE OF JURY                  [Signature]</p>		<p>38. SIGNATURE OF JURY                  [Signature]</p>		<p>39. SIGNATURE OF JURY                  [Signature]</p>	
<p>40. SIGNATURE OF JURY                  [Signature]</p>		<p>41. SIGNATURE OF JURY                  [Signature]</p>		<p>42. SIGNATURE OF JURY                  [Signature]</p>	
<p>43. SIGNATURE OF JURY                  [Signature]</p>		<p>44. SIGNATURE OF JURY                  [Signature]</p>		<p>45. SIGNATURE OF JURY                  [Signature]</p>	
<p>46. SIGNATURE OF JURY                  [Signature]</p>		<p>47. SIGNATURE OF JURY                  [Signature]</p>		<p>48. SIGNATURE OF JURY                  [Signature]</p>	
<p>49. SIGNATURE OF JURY                  [Signature]</p>		<p>50. SIGNATURE OF JURY                  [Signature]</p>		<p>51. SIGNATURE OF JURY                  [Signature]</p>	
<p>52. SIGNATURE OF JURY                  [Signature]</p>		<p>53. SIGNATURE OF JURY                  [Signature]</p>		<p>54. SIGNATURE OF JURY                  [Signature]</p>	
<p>55. SIGNATURE OF JURY                  [Signature]</p>		<p>56. SIGNATURE OF JURY                  [Signature]</p>		<p>57. SIGNATURE OF JURY                  [Signature]</p>	
<p>58. SIGNATURE OF JURY                  [Signature]</p>		<p>59. SIGNATURE OF JURY                  [Signature]</p>		<p>60. SIGNATURE OF JURY                  [Signature]</p>	
<p>61. SIGNATURE OF JURY                  [Signature]</p>		<p>62. SIGNATURE OF JURY                  [Signature]</p>		<p>63. SIGNATURE OF JURY                  [Signature]</p>	
<p>64. SIGNATURE OF JURY                  [Signature]</p>		<p>65. SIGNATURE OF JURY                  [Signature]</p>		<p>66. SIGNATURE OF JURY                  [Signature]</p>	
<p>67. SIGNATURE OF JURY                  [Signature]</p>		<p>68. SIGNATURE OF JURY                  [Signature]</p>		<p>69. SIGNATURE OF JURY                  [Signature]</p>	
<p>70. SIGNATURE OF JURY                  [Signature]</p>		<p>71. SIGNATURE OF JURY                  [Signature]</p>		<p>72. SIGNATURE OF JURY                  [Signature]</p>	
<p>73. SIGNATURE OF JURY                  [Signature]</p>		<p>74. SIGNATURE OF JURY                  [Signature]</p>		<p>75. SIGNATURE OF JURY                  [Signature]</p>	
<p>76. SIGNATURE OF JURY                  [Signature]</p>		<p>77. SIGNATURE OF JURY                  [Signature]</p>		<p>78. SIGNATURE OF JURY                  [Signature]</p>	
<p>79. SIGNATURE OF JURY                  [Signature]</p>		<p>80. SIGNATURE OF JURY                  [Signature]</p>		<p>81. SIGNATURE OF JURY                  [Signature]</p>	
<p>82. SIGNATURE OF JURY                  [Signature]</p>		<p>83. SIGNATURE OF JURY                  [Signature]</p>		<p>84. SIGNATURE OF JURY                  [Signature]</p>	
<p>85. SIGNATURE OF JURY                  [Signature]</p>		<p>86. SIGNATURE OF JURY                  [Signature]</p>		<p>87. SIGNATURE OF JURY                  [Signature]</p>	
<p>88. SIGNATURE OF JURY                  [Signature]</p>		<p>89. SIGNATURE OF JURY                  [Signature]</p>		<p>90. SIGNATURE OF JURY                  [Signature]</p>	
<p>91. SIGNATURE OF JURY                  [Signature]</p>		<p>92. SIGNATURE OF JURY                  [Signature]</p>		<p>93. SIGNATURE OF JURY                  [Signature]</p>	
<p>94. SIGNATURE OF JURY                  [Signature]</p>		<p>95. SIGNATURE OF JURY                  [Signature]</p>		<p>96. SIGNATURE OF JURY                  [Signature]</p>	
<p>97. SIGNATURE OF JURY                  [Signature]</p>		<p>98. SIGNATURE OF JURY                  [Signature]</p>		<p>99. SIGNATURE OF JURY                  [Signature]</p>	
<p>100. SIGNATURE OF JURY                  [Signature]</p>		<p>101. SIGNATURE OF JURY                  [Signature]</p>		<p>102. SIGNATURE OF JURY                  [Signature]</p>	



10167

# CERTIFICATE OF DEATH

10136

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East Rural</b>		c. LENGTH OF STAY IN 1b <b>15 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X North East Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nona Marie Gambill</b>			First Middle Last			4. DATE OF DEATH Month Day Year <b>Sept. 15 1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/25/1902</b>	
9. AGE (In years last birthday) <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Jefferson Co. N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Gambill</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Hall Gambill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>192-12-6595</b>		17. INFORMANT Address <b>Samuel Gambill Nort East, Md. R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coccarcinoma of Breast</b> DUE TO <b>Coccarcinoma of Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coccarcinoma of Breast</b> DUE TO <b>Coccarcinoma of Breast</b> (c) <b>Coccarcinoma of Breast</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 10, 1954</b> to <b>Sept 15, 1959</b> , that I last saw the deceased alive on <b>Sept 15, 1959</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>54 N. West - Oxford - Pa.</b> DATE SIGNED <b>Sept 18 '59</b>							
ACTUAL SIGNATURE <b>John B. Hulse</b>		PHYSICIAN'S NAME (Type) <b>John B. Hulse</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/18/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Conowingo Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Conowingo Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson Rising</b>				ADDRESS <b>Rising Sun, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 18 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Chas. E. Hulse</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10147

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>W.</u> Last <u>GORIN</u>				4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-59</u>	
9. AGE (In years lost birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u> Hours <u>30</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Amos W. Gorin</u>				14. MOTHER'S MAIDEN NAME <u>Betty Everly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Amos W. Gorin</u>		Address <u>Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ob phaloccele</u> <u>756.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/8/59</u> to <u>9/9/59</u> that I last saw the deceased alive on <u>9/8/59</u> and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Fischer</u> M.D.				ADDRESS (Street, city or town, state) <u>162 W. Main ST. Elkton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John A. Fischer</u>				DATE SIGNED <u>9/10/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10137

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

10137

3

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10162

## CERTIFICATE OF DEATH

10138

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>9 mo. 8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Chester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75 x 3</b> d. STREET ADDRESS <b>121 Lewis Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES H. ISABELL</b>		4. DATE OF DEATH Month Day Year <b>September 30 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>(Sep)</b>	8. DATE OF BIRTH <b>2-1-21</b>
9. AGE (In years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George Isabell (Deceased)</b>	
14. MOTHER'S MAIDEN NAME <b>Emma Johnson (Deceased)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> DUE TO <b>Chronic brain syndrome of uncertain cause</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>unknown</b> (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 22 19 58</b> , to <b>September 30 19 59</b> and that death occurred at <b>4:45 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>V.A. Hospital, Perry Point, Md. 10-2-59</b>			
ACTUAL SIGNATURE <b>J. L. GAREY</b>		PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b> <b>Clinical Pathologist</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10/2/59</b>		22b. DATE THEREOF <b>10/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pennington &amp; Son, Havre de Grace, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Beckley W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Kinn</b>			

10162

CERTIFICATE OF DEATH

10162

Cecil

Tennessee

Army - 10162

5 mo. 8 days

Chesapeake

Veterans Administration Hospital

121 Lewis Street

Male

10162

(1907)

1-1-21

38

Unknown

West Virginia

George Isbell (Deceased)

John Johnson (Deceased)

W II

Unknown

Hospital Records, V.A. Army, 10162

Encephalomyelitis, bilateral, unspecified

7-10 days

Chronic brain syndrome of uncertain cause

unknown

ix

VI

September 22 58

September 20 58

XXXXXXXXXXXXXXXXXXXX

J. I. GARY

Clinical Pathologist

V.A. Hospital, Perry Point, Md. 10-2-58

Examination of body, 10 days, 10



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10139

10163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>				c. LENGTH OF STAY IN 1b <b>10 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VAH., Perry Point</b>				d. STREET ADDRESS <b>546 Baker Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>JOHNSON</b> Last <b>JOHNSON</b>				4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/5/00</b>		9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.	IF UNDER 24 HRS. Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ed JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>Rachel (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 213-16-5045</b>		INFORMANT Address <b>Hospital Records, VA Hospital, Perry Point, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHIAL PNEUMONIA</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 26, 19 59</b> to <b>September 4, 19 59</b> and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, Perry Point, Md. 9-5-59</b>							
ACTUAL SIGNATURE <b>Joseph M. Hooper, M.D.</b> M.D.				PHYSICIAN'S NAME (Type) <b>JOSEPH M. HOOPER, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>KELSON FUNERAL HOME, 1348 N. Calhoun St. Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 11 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Harris</b>	

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4128 J. Neurosci., September 24, 2008 • 28(39):4123–4132

North Carolina State University

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

[illegible]

Ann. Entomol. Soc. Am. 51: 101-107, 1958.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10148

## CERTIFICATE OF DEATH

10140

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 2 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DEVINE HAVEN NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Kelso		4. DATE OF DEATH Month Day Year Sept. 8 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK KEEPER		10b. KIND OF BUSINESS OR INDUSTRY RECORDS	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT JOHNSON		14. MOTHER'S MAIDEN NAME LIDIA BOGART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) —	
17. INFORMANT Address WILLIAM D'AZEVEDO ELKTON, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3 DUE TO Carcinoma of sigmoid. (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH July 28	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1959 to Sept. 8, 1959, that I last saw the deceased alive on Sept 8, 1959, and that death occurred at 12:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Milford H. Spiecher M.D.		DATE SIGNED Sept 8 1959	
PHYSICIAN'S NAME (Type) MILFORD H. SPRECHER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 10, 1959	
22c. NAME OF CEMETERY OR CREMATORY RIVER SIDE CEMETERY		22d. LOCATION (City, town, or county) (State) TOMS RIVER N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS ELKTON, MD.	
24a. REC'D BY REGISTRAR DATE SEP 11 1959		24b. REGISTRAR'S SIGNATURE	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10141

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10164

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecil North East</b> c. LENGTH OF STAY IN 1b <b>10yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>OSCAR</b> Middle <b>M.</b> Last <b>KIBLER</b>				<b>4. DATE OF DEATH</b> Month <b>9</b> Day <b>13</b> Year <b>1959</b>					
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>11-26-1886</b>		<b>9. AGE</b> (In years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Building</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John Kibler</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Jenny Comer</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>220-14-5912</b>		<b>17. INFORMANT</b> Address <b>Mrs. Louise S. Kibler, North East, Md.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <i>R.C. Dodson</i>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>EXAMINER'S NAME (Type)</b> <b>R.C. Dodson</b>				<b>DATE SIGNED</b> <b>9-14-59</b>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>9-16-59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Methodist North East Md.</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>North East Cecil Md.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Joseph R. Grant</i>				<b>ADDRESS</b> <b>North East Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>SEP 17 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur J. K...</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
MARRIAGE		OCCUPATION	
EDUCATION		RELIGION	
MANNER OF DEATH		CAUSE OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
CYTOLOGICAL FINDINGS		IMMUNOHISTOCHEMISTRY	
MOLECULAR FINDINGS		GENETIC FINDINGS	
IMMUNOLOGICAL FINDINGS		TOXICOLOGICAL FINDINGS	
PHARMACOLOGICAL FINDINGS		ENVIRONMENTAL FINDINGS	
Epidemiological Findings		Public Health Findings	
Legal Findings		Administrative Findings	
Other Findings		Remarks	

1

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 01-11-2001 BY 60322 UCBAW



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East Rural</b>		c. LENGTH OF STAY IN 1b <b>all life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Andrew Jackson Lockard</b>				4. DATE OF DEATH Month Day Year <b>9 28 19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>M</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-1906</b>		9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>just labor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Lockard</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hannah Pearce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>221-09-9457</b>		17. INFORMANT <b>William Lockard, Bear, Delaware</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary</b> <b>4-20-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>10-5-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-6-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>North East Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>North East Cecil Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Traut</b>				ADDRESS <b>North East Md</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carlton E. Traut</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10143

## 10149 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		LENGTH OF STAY (in this place) 43 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 213 E. High Street				STREET ADDRESS (If rural give location) 213 E. High Street			
<b>3. NAME OF DECEASED</b> (Type or Print) James Edward Milburn				<b>4. DATE OF DEATH</b> (Month) 9 (Day) 24 (Year) 1959			
<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> Col.	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> Married	<b>8. DATE OF BIRTH</b> Aug. 10, 1871		<b>9. AGE last birthday</b> 88 yrs.	<b>IF UNDER 1 YEAR</b> Months Days	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Janitor		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) Maryland		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> John W. Milburn				<b>14. MOTHER'S MAIDEN NAME</b> Susan T. Evans			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) none		<b>16. SOCIAL SECURITY NO.</b> none		<b>17. INFORMANT &amp; ADDRESS</b> Emma Milburn-213 E. High St.			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
331X IMMEDIATE CAUSE (A) Cerebral Accident						INTERVAL BETWEEN ONSET AND DEATH 5 day	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension						10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cardiac &						10 yrs.	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)				<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)				<b>21e. INJURY OCCURRED</b> While at work Not while at work		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from January 6, 1959, to Sept 24, 1959, that I last saw the deceased alive on Sept 23, 1959, and that death occurred at 2 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> James H. Johnson				<b>ADDRESS</b> (Street, city, town, state) 2455. High St. Elkton			
<b>DATE SIGNED</b> 9/25/59				<b>DATE SIGNED</b> 9/25/59			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>DATE THEREOF</b> 9/26/59		<b>NAME OF CEMETERY OR CREMATORY</b> Providence Cem.		<b>LOCATION</b> (City, town, or county) Elkton, Maryland	
<b>24. REC'D BY REGISTRAR</b> DATE SEP 28 '59		<b>REGISTRAR'S SIGNATURE</b> Arthur S. Thomas		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> John R. Beel		<b>ADDRESS</b> 909 Poplar St.	



may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10144

10166

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>Pittsburgh</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>9yrs.2mo.27days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1531 Scott Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>J.</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>September</b> Day <b>13</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-9-85</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sign</b>			
13. FATHER'S NAME <b>Abraham Miller</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Hospital Records, VAN, Perry Point, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Few minutes</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 15</b> , 19 <b>50</b> , to <b>Sept. 13</b> , 19 <b>59</b> , and that death occurred at <b>5:30pm</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>B. S. Linn</b>				M.D. <b>V.A. Hospital, Perry Point, Md. 9-14-59</b>			
PHYSICIAN'S NAME (Type) <b>B. S. LINN</b>				Staff Physician			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>				22b. DATE THEREOF <b>9/15/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>unknown</b>				22d. LOCATION (City, town, or county) (State) <b>Pittsburgh, Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>				ADDRESS <b>Havre de Grace, Md.</b>			
24a. REC'D BY REGISTRAR <b>SEP 18 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kinn</b>			



1916

1916

Geoff

Pennsylvania

May 1916

May 1916

Pittsburgh

Veterans Administration Hospital

1551 North Lane

Miller

Miller

September 15

Male

White

9-1-15

74

Printer

Union

Pennsylvania

USA

Unknown

Unknown

15

15

Unknown

Unknown

Unknown

Myocardial Infarction

Coronary arteriosclerosis

Few others

Sept. 15

June 15

Pittsburgh, Pa.

Unknown

Harve de Grace, Md.

Harve de Grace, Md.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10145

Reg. Dist. No. 96

10167

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN lb <b>26 Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Northeast</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital, Perry Point, Md.</b>				d. STREET ADDRESS <b>None (Rural)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>J.</b> Last <b>NICELY</b>				4. DATE OF DEATH Month <b>9-</b> Day <b>12-</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-2-96</b>		9. AGE (in years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>224 01 3611</b>		17. INFORMANT Address <b>HOSPITAL RECORDS, VAH, PERRY POINT, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>26 Hours</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R.C. Dodson</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. DODSON, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>9/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Big Rock Church</b>		22d. LOCATION (City, town, or county) (State) <b>Clifton Forge, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington &amp; Son</i> ADDRESS <b>Pennington &amp; Son, Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 18 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hous</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10168

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11293

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Locust Point, Elkton		c. LENGTH OF STAY IN 1b 2.5 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R. D. #2 Locust Pt.		d. STREET ADDRESS R. D. #2, Locust Pt.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hulett Edward Palmer		4. DATE OF DEATH Month Day Year Sept. 29 19 59	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Bainbridge NTC	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Palmer		14. MOTHER'S MAIDEN NAME Sarah Kincaid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-3942	
17. INFORMANT James F. Murphy, Locust Pt. RD #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accute Coronary 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 9-30-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3, 1959	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		22d. LOCATION (City, town, or county) (State) nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pipppin Funeral Home		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR DATE OCT 8 '59		24b. REGISTRAR'S SIGNATURE Christina A. Howard	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10146

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>		c. LENGTH OF STAY IN lb <b>2 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rising Sun</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>	
f. STREET ADDRESS <b>Cor. Cherry and Walnut</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle <b>M</b> Last <b>Palmer</b>		4. DATE OF DEATH Month <b>9</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-17-1957</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>17</b>	
11. IF UNDER 24 HRS. Hours <b>17</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>West Grove, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl Edward Palmer</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Anne Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Barbara A. Palmer, Rising Sun, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>983x Intre Abdominal Hemorrhage</b> DUE TO (b) <b>Lacerated liver and mesentery of large intestine</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Whipped to death by Edward Paul McGue, Jr.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7</b> p. m. <b>9 3</b> 19 <b>59</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> Home <b>Rising Sun Cecil Md.</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-11-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Sept 11 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Oxford Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M. Reed, Rising Sun, Md</b>		24a. REC'D BY REGISTRAR <b>SEP 11 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Carl M. Jones</b>	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <b>John Doe</b>		AGE <b>45</b>	
SEX <b>Male</b>		RACE <b>White</b>	
DATE OF DEATH <b>1-1-1911</b>		PLACE OF DEATH <b>Home</b>	
RESIDENCE <b>123 Main St. Baltimore, Md.</b>		OCCUPATION <b>Teacher</b>	
CAUSE OF DEATH <b>Myocardial Infarction</b>		MANNER OF DEATH <b>Natural</b>	
SIGNATURE OF EXAMINER <b>J. H. Smith</b>		DATE <b>1-1-1911</b>	
LOCALITY <b>Baltimore, Md.</b>		COUNTY <b>Harford</b>	
STATE <b>Md.</b>		FEDERAL DISTRICT <b>1st</b>	
JURY <b>Yes</b>		CORONER <b>Yes</b>	
BURIAL <b>Yes</b>		CREMATION <b>No</b>	
INTERMENT <b>Yes</b>		OTHER <b>No</b>	
REMARKS <b>Heart attack while at work.</b>		SIGNATURE OF JURY <b>Yes</b>	
SIGNATURE OF CORONER <b>J. H. Smith</b>		DATE <b>1-1-1911</b>	
LOCALITY <b>Baltimore, Md.</b>		COUNTY <b>Harford</b>	
STATE <b>Md.</b>		FEDERAL DISTRICT <b>1st</b>	
JURY <b>Yes</b>		CORONER <b>Yes</b>	
BURIAL <b>Yes</b>		CREMATION <b>No</b>	
INTERMENT <b>Yes</b>		OTHER <b>No</b>	
REMARKS <b>Heart attack while at work.</b>		SIGNATURE OF JURY <b>Yes</b>	



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10147

10170

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Md.</b>		c. LENGTH OF STAY IN 1b <b>17 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VA. Hospital</b>		d. STREET ADDRESS <b>1 S. Reed street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Winfield</b> Middle <b>S</b> Last <b>PARKS</b>		4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/92</b>
9. AGE (In years last birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar Tender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saloon</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred Parks</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
INFORMANT <b>VA Hospital records. Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>527.1</b> IMMEDIATE CAUSE (a) <b>EMPHYSEMA, Chronic, Pulmonary.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 21, 1959</b> to <b>September 7, 1959</b> and that death occurred at <b>11: A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, Perry Point, Md. 9-7-59</b>			
ACTUAL SIGNATURE <b>B. Rothfeld</b>		M.D. <b>VA Hospital, Perry Point, Md. 9-7-59</b>	
PHYSICIAN'S NAME (Type) <b>B. ROTHFELD, M.D. Staff Physician.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-10-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Belair, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. G. KURTZ FUNERAL HOME.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 10 '59</b>	
ADDRESS <b>Jarrettsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiana</b>	

10170

CERTIFICATE OF DEATH

CHAS. C. C. C.

Residing at No. 12

12 Days

VA. HOSPITAL

W. H. H.

10170

For Under

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10171

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural North East</b>				c. LENGTH OF STAY IN 1b <b>27 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Reino</b> Middle <b>Jacob</b> Last <b>Passi</b>				4. DATE OF DEATH Month <b>9</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 14 1905</b>		9. AGE (In years last birthday) <b>53</b> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter Poultry Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wyoming</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jacob Passi</b>			14. MOTHER'S MAIDEN NAME <b>Sanna Syynomaa</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-18-2695</b>		17. INFORMANT <b>Mrs Reino Passi North East, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Hypertensive Cardiovascular renal disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>5 yrs.</b> <b>14 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1949</b> , to <b>16 Sept. 1959</b> , that I last saw the deceased alive on <b>9 Sept. 1959</b> , and that death occurred at <b>4:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>North East Rd</b> DATE SIGNED <b>16 Sept '59</b>							
ACTUAL SIGNATURE <b>Klaus H. Huchner</b> M.D.		PHYSICIAN'S NAME (Type) <b>Klaus H Huchner M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9 19 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>North east Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b> ADDRESS <b>North East, Maryland</b>				24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Klaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 FilmG248 9-14-59 et  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

10149

10150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>1 Hr 47 Min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				d. STREET ADDRESS <b>Rd 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby Girl</b> Middle <b>Rasnake</b> Last				4. DATE OF DEATH Month <b>9</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-1959</b>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Curtis Rasnake</b>				14. MOTHER'S MAIDEN NAME <b>Peggy Lou Barton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT Address <b>Curtis Rasnake Elkton Rd 1, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>761.5 Sack respiratory failure</b> DUE TO (b) <b>Pneumonia</b> DUE TO (c) <b>Pneumonia rupture of membranes</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-8</b> , 19 <b>59</b> to <b>9-8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-8</b> , 19 <b>59</b> , and that death occurred at <b>12:40 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 W. Main</b> DATE SIGNED <b>9-8-59</b> ACTUAL SIGNATURE <b>Peter Stank</b> M.D. <b>PETER STANK M.D.</b> PHYSICIAN'S NAME (Type) <b>PETER STANK M.D.</b> <b>ELKTON Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-9-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East, Cecil., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				ADDRESS <b>North East Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles E. Howard</b>			

2065234XV0

2012-2013



10151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 E. HIGH ST				d. STREET ADDRESS 115 E. High Street, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BERTHA		First Middle Last MAE REALEY		4. DATE OF DEATH Sept. 11 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1880		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Cecil Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Information				14. MOTHER'S MAIDEN NAME No Information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Wm. W. Singleton, 115 E. High St., Elkton Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 8, 19 58, to Sept. 11, 19 59, that I last saw the deceased alive on Sept. 11, 19 59, and that death occurred at 5:40 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.				ADDRESS (Street, city or town, state) 233 E. Main Street		DATE SIGNED Sept. 12, 1959	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-59		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Pk. Elkton, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald R. See Elkton,				24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hunt	



10172

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun Rural</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun Rural</b>	
c. LENGTH OF STAY IN 1b <b>80 yrs.</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Adolphus</b> Last <b>Reeder</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 25 1878</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Line Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Rising Sun, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Maurice Reeder</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Maxwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. William Reeder</b> Address <b>Rising Sun Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis and senility</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 6</b> , 19 <b>59</b> , to <b>8-10-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-9-59</b> , 19 <b>59</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b> DATE SIGNED <b>9-12-59</b>			
ACTUAL SIGNATURE <b>R.C. Dodson</b> M.D.			
PHYSICIAN'S NAME (Type) <b>R.C. Dodson</b> <b>Rising Sun, Md.</b> <b>9-12-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 14, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>	22d. LOCATION (City, town, or county) (State) <b>Near Colora Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Lyson</b> ADDRESS <b>Rising Sun, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 15 59</b>	24b. REGISTRAR'S SIGNATURE <b>C. L. Jones</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

10112

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
Item 20 Film 249 9-25-59 ams														
10173														
CERTIFICATE OF DEATH														
Reg. Dist. No. 96														
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>					d. STREET ADDRESS <b>R.D. 4, Box 88</b>									
3. NAME OF DECEASED (Type or print) First <b>LUIS</b> Middle <b>SANCHEZ-</b> Last <b>MARIN</b>					4. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>19 59</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-11-14</b>		9. AGE (In years last birthday) <b>44</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Puerto Rico</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Leocadio Sanchez</b>					14. MOTHER'S MAIDEN NAME <b>Felicita Marin</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>					16. SOCIAL SECURITY NO. <b>175-28-2775</b>					INFORMANT Address <b>Hospital Records, VAM, Perry Point, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalopathy due to anoxia</b> DUE TO <b>950x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Arrest</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shook following operation due to injury of lumbar artery, right</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>12 hrs.</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Herniation of nucleus pulposus L 4-L 5 (R)</b>									
20c. TIME OF INJURY Month, Day, Year <b>9/14/59</b> Hour a. m. <b>10AM</b> p. m. <b>VA</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Perry Point</b> (County) <b>Cecil</b> (State) <b>Md</b>							
21. I certify that I attended the deceased from <b>September 5 1959</b> , to <b>Sept. 15</b> , 19 <b>59</b> , and that death occurred at <b>4:00a</b> AM, from the causes and on the date stated above.														
ACTUAL SIGNATURE <b>Louis G. Cian</b>					ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>9-15-59</b>									
PHYSICIAN'S NAME (Type) <b>L. G. CIAN</b>					Staff Physician									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>9-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>			22d. LOCATION (City, town, or county) <b>Havre de Grace, Md.</b> (State)						
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Havre de Grace, Md.</b>					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							

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• *Journal of the American Medical Association*, 1997; 277: 1033-1037

10/1/96



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10153

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>3hr15min</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle <b>B.</b> Last <b>SAPP</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>27,</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 29, 1920</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Northeast, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Phillip Sapp</b>				14. MOTHER'S MAIDEN NAME <b>Ethel Murphy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW11</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, extreme</b> DUE TO (c) <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R. C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R. C. DODSON, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Sept 30 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception Cem.</b>	
22d. LOCATION (City, town, or county) <b>Bikton, (Rural) Cecil Maryland.</b>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>				ADDRESS <b>Grant North East, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>							

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10170 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b> 75x-3	
c. LENGTH OF STAY IN 1b <b>visiting</b>		d. STREET ADDRESS <b>225</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Malvin</b> Middle <b>Harry</b> Last <b>Seiders</b>		4. DATE OF DEATH Month <b>9</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-2-1924</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beth. Steel Coke Ovens</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Ind.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emmanuel Seiders</b>		14. MOTHER'S MAIDEN NAME <b>VernaKeeper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mrs. Melvin H. Seiders, 225 Middletown, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowned</b> 850x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Boat Upset in Susquehanna River, Cecil Co. Md.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9 11 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Susquehanna River</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Port Deposit Cecil Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>9-12-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Middletown</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown Dauphin Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thermon M. Miller</b>		24a. REC'D BY REGISTRAR <b>Rising Sun Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>SEP 15 '59</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6248 9-18-59 et

10155

10176

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>				c. LENGTH OF STAY IN 1b <b>40 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W.</b> Last <b>Snelling</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>13,</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1894</b>		9. AGE (In years last birthday) <b>64</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Equipment Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Vet. Administrat.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert L. Snelling</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Bouchyard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>203-07-1877</b>		INFORMANT Address <b>Edith Fredrick Snelling, Perryville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Cardiac failure type IV</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Perryville</b>		20f. (City or town) (County) (State) <b>Cecil Md 2d</b>	
21. I certify that I attended the deceased from <b>January 19 58</b> to <b>Sept 13, 19 59</b> , that I last saw the deceased alive on <b>Sept 13, 19 59</b> , and that death occurred at <b>11:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>E. J. Simon</b> M.D. <b>HARVEY GRACE, Md 9-14-59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>E. J. SIMON M.D.</b> <b>HARVEY DE GRACE, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-16-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 16 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10178

Local

Birth Date

Age

Residence

Sex

Color

DECEASED

NAME

AGE

DATE OF DEATH

PLACE OF DEATH

SEX

RACE

CAUSE OF DEATH

DIAGNOSIS

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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DATE OF BIRTH

PLACE OF BIRTH

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CAUSE OF DEATH

DIAGNOSIS

DATE OF BIRTH



10177

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryvil 1 e</b>		c. LENGTH OF STAY IN 1b <b>42Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Blanche</b> Last <b>Todd</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>16,</b> Year <b>19 59</b>	
5. SEX <b>Fem ale</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26, 1886</b>
9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emory Shores</b>		14. MOTHER'S MAIDEN NAME <b>Margaret White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Phillip Todd</b>		Address <b>Perryville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction - failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Intestinal obstruction (Malignant)</b> DUE TO (c) <b>Anterior scissus atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>8 wks</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-11</b> , 19 <b>55</b> , to <b>9-16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-16</b> , 19 <b>59</b> , and that death occurred at <b>1:00 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. H. Richards</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Port Deposit, Md. 9/16/59</b>	
PHYSICIAN'S NAME (Type) <b>G. H. Richards M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-18-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson, Inc.</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Evans</b>	

1

Page 4

death. The law requires that the death certificate be executed within 24 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10157

10178

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nottingham R.D.</u> c. LENGTH OF STAY IN 1b <u>8 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Graybeal Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u> d. STREET ADDRESS <u>12X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Arthur Linn Trago</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>9 22 19 59</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10/19/77</u> <u>10-19-1877</u>	<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm (Retired)</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			<b>13. FATHER'S NAME</b> <u>William Arthur Trago</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Alice Coale</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				
<b>16. SOCIAL SECURITY NO.</b> <u>Graybeal Nursing Home, Nottingham, R.D. 1 Pa.</u>			<b>17. INFORMANT</b> Address				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)	<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>R.C. Dodson</u> M.D.		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>9-22-59</u>			
<b>EXAMINER'S NAME</b> (Type) <u>R.C. Dodson</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>buried</u>	<b>22b. DATE THEREOF</b> <u>9/24/59</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Churchville Presbyterian</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Churchville Maryland</u>				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John E. Herring Aberdeen, Maryland</u>			<b>24a. REC'D BY REGISTRAR</b> <u>SEP 24 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Cuthbert A. Hines</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10152

CERTIFICATE OF DEATH

Reg. Dist. No.

10158

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>73</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTRAM</u> Middle <u>WARD</u> Last <u>WARD</u>		4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ward</u>		14. MOTHER'S MAIDEN NAME <u>Mary Calvert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-10-1868</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA STOMACH</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO SCLEROTIC HEART DISEASE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/24</u> , 19 <u>59</u> , to <u>9/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/7</u> , 19 <u>59</u> , and that death occurred at <u>4:05 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Fischer</u>		ADDRESS (Street, city or town, state) <u>162 W. MAIN ST. ELKTON, MD.</u>	
PHYSICIAN'S NAME (Type) <u>John A. Fischer</u>		DATE SIGNED <u>9/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>North East Methodist Ch</u>		22d. LOCATION (City, town, County) (State) <u>North East Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter duBois Jr.</u>		ADDRESS <u>Elkton</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Gordon S. Howard</u>	
DATE <u>SEP 11 '59</u>			

CERTIFICATE OF DEATH

10152

218-10-1068



## CERTIFICATE OF DEATH

Reg. Dist. No.

10159

10179

1. PLACE OF DEATH  
a. COUNTY

Cecil

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Perry Point, Md.

c. LENGTH OF STAY IN 1b

58 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

2212-2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Veterans Administration Hospital

d. STREET ADDRESS

405 Hammond Street

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

Grover

Cleveland

Wilson

## 4. DATE OF DEATH

Month

Day

Year

September

25,

19 59

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## 8. DATE OF BIRTH

4-22-17

## 9. AGE (In years last birthday)

42 yrs.

## IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cloth Spreader

10b. KIND OF BUSINESS OR INDUSTRY

Shirt Factory

11. BIRTHPLACE (State or foreign country)

Crisfield, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

William Wilson

## 14. MOTHER'S MAIDEN NAME

Addie Dize

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

yes

If yes, give war or dates of service

WW II

16. SOCIAL SECURITY NO.

158 09 6325

INFORMANT

Mrs. Minnie M. Wilson (Wife) 405 Hammond St. Salisbury, Md. Hospital Records, VA Hospital, Perry Point, Md.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

BRONCHIAL PNEUMONIA - Bilateral, Unresolved

INTERVAL BETWEEN ONSET AND DEATH

10-12 Days

DUE TO

Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.

(b)

BRONCHOGENIC CA, Rt Lung, w/ Metus to hilar nodes &amp; to brain.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m.  
p. m.

VA

19

20d. INJURY OCCURRED

While ☐ Not while ☐  
at work of work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 6-28, 1959, to 9-25, 1959.

and that death occurred at 11:15 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

[Signature]

M.D.

VA Hospital, Perry Point, Md.

PHYSICIAN'S NAME (Type)

Dr. EMMETT J. GAREY

VAH., Perry Point, Md.

9/26/59

22a. BURIAL, CREMATION, or other disposal (Specify)

Burial

22b. DATE THEREOF

Sep. 30, 1959

22c. NAME OF CEMETERY OR CREMATORY

Wicomico Memorial Park

22d. LOCATION (City, town, or county)

Salisbury, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

BOLLOWAY &amp; CO.

ADDRESS

Salisbury, Maryland.

24a. REC'D BY REGISTRAR

DATE

SEP 29 1959

24b. REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2. Page 2 of 2. Page 3 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10172

Cecil

Wilson

Wilson

Wilson

88 days

Perky John, MA.

Verona Administration Hospital

405 Belmont Street

Grover

Civilian

Wilson

September 25

Male

White

4-22-17

48

Oliver Spender

Garvey Factory

Griffiths, MA.

U.S.A.

William Wilson

Adults 1710

108 OF 6785

WM II

Yes

Verona Administration Hospital, 405 Belmont Street, MA.

VERONA ADMINISTRATION - BELMONT, MA.

VERONA ADMINISTRATION - BELMONT, MA.

to be

VA

6-22

6-22

6-22

11:15

VA Hospital, Perky John, MA.

VA, Perky John, MA.

IN NAME OF

Sum of

Verona Administration Hospital

Verona Administration Hospital

Verona Administration Hospital

6-22

Verona Administration Hospital